INFORMATION AND PERMISSION – AIR SHOW SUPPORT TEAM

THIS INFORMATION MUST BE COMPLETE AND ACCURATE

(This Form has Two Pages)

NAME (Last, First, MI)	☐SENIOR MEMBER ☐ CADET

RANK	CAPID	UNIT NAME	UNIT CHARTER NUMBER

COMPLETE ADDRESS (Street, City, State, Zip)	TELEPHONE NUMBERS (AREA CODE)

AGE	BIRTH DATE	SEX	HEIGHT	WEIGHT

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	DAY PHONE	NIGHT PHONE
ALTERNATE EMERGENCY CONTACT	RELATIONSHIP	DAY PHONE	NIGHT PHONE

PHYSICIAN	TELEPHONE	PREFERRED HOSPITAL NEAR DAYTON, OH

DATE OF LAST TETANUS SHOT

MEDICAL HISTORY, PROBLEMS, DIET, AND RESTRICTIONS (Physical or Medical)

ALLERGIES TO MEDICATIONS (If None, Write “NONE”)

ALLERGIES TO FOOD (If None, Write “NONE”)

SEND ONLY MEDICATION THAT IS ABSOLUTELY NECESSARY. MEDICATIONS SHOULD BE IN THE ORIGINAL CONTAINER, WITH USER’S NAME, DIRECTIONS, DOSAGE, AND NAME OF MEDICINE. ONLY SEND THE AMOUNT OF MEDICINE THAT WILL BE NEEDED FOR THE DURATION OF THE AIR SHOW.

MEDICATION	PRESCRIBED FOR	DOSAGE	WHEN TAKEN

I CERTIFY THAT THE PRECEDING INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

SIGNATURE OF APPLICANT DATE

RELEASE BY PARENT OR GUARDIAN (For Applicants Under Age 18)

FOR AND IN CONSIDERATION OF THE BENEFITS _____ DERIVES BY PARTICIPATING IN THE AIR SHOW SUPPORT TEAM ACTIVITIES I, AS PARENT OR GUARDIAN OF SAID MINOR CHILD, DO HEREBY FOR MYSELF, MY HEIRS, EXECUTORS, AND ADMINISTRATORS REMISE, RELEASE, AND FOREVER DISCHARGE THE GOVERNMENT OF THE UNITED STATES OF AMERICA, CIVIL AIR PATROL INC., ALL OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS, ACTING OFFICIALLY OR OTHERWISE, OF BOTH THE UNITED STATES OF AMERICA AND CIVIL AIR PATROL INC. FROM ANY AND ALL CLAIMS, ACTIONS, OR CAUSES OF ACTION ON ACCOUNT OF THE DEATH OF OR INJURY TO THE APPLICANT WHICH MAY OCCUR BY THE ACTIVITIES OF THE AIR SHOW SUPPORT TEAM. IN ADDITION, BY MY SIGNATURE BELOW I CERTIFY THE APPLICANT:

A) IS MY MINOR CHILD OR WARD?
B) WAS BORN ON _____.
C) HAS NO HISTORY OF INJURY OR DISEASE, WHICH MIGHT BE AFFECTED BY THIS ACTIVITY EXCEPT AS DESCRIBED ABOVE.

HOWEVER, IN CASE OF INJURY, DISEASE, OR OTHER ILLNESS PERMISSION IS HEREBY GRANTED TO TREAT THE APPLICANT AS REQUIRED. I WILL BE RESPONSIBLE FOR FURTHER TREATMENT IF THE APPLICANT IS RELEASED FROM THE ACTIVITY BEFORE RECOVERY.

_____ _____ _____

NAME OF PARENT OR LEGAL GUARDIAN SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

THIS SECTION FOR USE BY MEDICAL STAFF

FOR OFFICE USE

☐ ACCEPTED ☐ REJECTED TEAM ASSIGNMENT: _____

TEAM LEADER: _____